EDMUND G. BROWN JR., Attorney General
of the State of California
JAMES M. LEDAKIS
Supervising Deputy Attorney General
ERIN M. SUNSERI, State Bar No. 207031
Deputy Attorney General
110 West "A" Street, Suite 1100
San Diego, CA 92101

P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2071
Facsimile: (619) 645-2061

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MONA LEE WILLIAMS 25407 Allesandro Blvd., Apt. 424 Moreno Valley, CA 92553 24850 Hancock Ave, #B204 Murrietta, CA 92562 Registered Nurse License No. 692725 Respondent.	Case No. 2009-152 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about November 17, 2006, the Board of Registered Nursing issued Registered Nurse License Number 692725 to Mona Lee Williams (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and expired on November 30, 2008.

///

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
>
> . . . .
>
> (d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it.
>
> . . . .

7. Section 2762 of the Code states:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> . . . .

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

. . . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

8. Section 2770.11 of the Code states:

(a) Each registered nurse who requests participation in a diversion program shall agree to cooperate with the rehabilitation program designed by a committee. Any failure to comply with the provisions of a rehabilitation program may result in termination of the registered nurse's participation in a program. The name and license number of a registered nurse who is terminated for any reason, other than successful completion, shall be reported to the board's enforcement program.

(b) If a committee determines that a registered nurse, who is denied admission into the program or terminated from the program, presents a threat to the public or his or her own health and safety, the committee shall report the name and license number, along with a copy of all diversion records for that registered nurse, to the board' s enforcement program. The board may use any of the records it receives under this subdivision in any disciplinary proceeding.

9. California Code of Regulations, title 16, section 1447 states:

An applicant shall meet the following criteria for admission to the program:

(a) Is a registered nurse licensed in this state.

(b) Resides in California.

(c) Is mentally ill or abuses alcohol and/or drugs in a manner which may affect the applicant's ability to safely perform the duties of a registered nurse.

(d) Voluntarily requests admission to the program.

(e) Agrees to undergo reasonable medical and/or psychiatric examinations necessary for evaluation for participation in the program.

(f) Cooperates by providing such medical information, disclosure authorizations and releases of liability as may be requested by the committee.

(g) Agrees in writing to comply with all elements of the diversion program.

(h) Has not had her/his license previously disciplined by the Board for substance abuse or mental illness.

(i) Has not been terminated from this or any other diversion program for non-compliance.

10. California Code of Regulations, title 16, section 1448 states:

The committee may terminate a nurse's participation in the program for any of the following reasons:

(a) Successful completion of the program designated by the committee.

(b) Failure to comply with the rehabilitation program designated by the committee.

(c) Failure to comply with any of the requirements set forth in Section 1447.

(d) Failure to substantially benefit from participation in the program.

(e) Receipt of information by the board which, after investigation, indicates the participant may have violated a provision of the laws governing the practice of nursing, Chapter 6 (commencing with Section 2700) of Division 2 of the Code, excluding Section 2762.

11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

12. Valium, a brand name for diazepam, is a Schedule IV controlled substance as designated by Health and Safety Code Section 11057(d)(9), and is a dangerous drug pursuant to Business and Professions Code section 4022.

13. Amphetamine and Methamphetamine are Schedule II controlled substances as designated by Health and Safety Code section 11055, subdivisions (d)(1) and (d)(2), respectively, and are dangerous drugs pursuant to Business and Professions Code section 4022.

14. Section 4022 of the Code states:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

FACTS

15. On or about March 3, 2008, Respondent was working her third shift as a new employee at Montclair Hospital Medical Center in Montclair, California. Nurse DF was assigned to precept Respondent on the night shift in the telemetry (cardiac) unit; they were to divide their assigned patients between them.

16. At approximately 8:20 p.m., Respondent asked Nurse DF to sign off on wastage in the Pyxis Medstation ("Pyxis"). The Pyxis typically interfaces with the hospital's pharmacy computer. Physicians' orders are entered into the pharmacy computer and then transferred to the Pyxis; patient profiles are displayed to the nurse who accesses the medications for verified orders. Each nurse is provided with a password that must be used to open Pyxis to access controlled substances. The wastage of leftover controlled substances must be witnessed by two persons who are required to make an entry into Pyxis using their password. Nurse DF signed for but did not actually witness the wastage.

17. At approximately 11:30 p.m., Nurse DF checked the Pyxis records and discovered that Respondent had taken out an order for Dilaudid on an unassigned patient in the surgical unit, and that Nurse DF was listed as witnessing wastage on a patient that did not belong to them. Nurse DF immediately reported the discrepancy to the charge nurse and the house supervisor. Nurse DF was told to report the incident to the unit manager when she came in at 6 a.m.

18. At approximately 2 a.m., on March 4, 2008, Respondent asked Nurse DF to sign for morphine wastage on a patient in Room 125-A. Respondent was carrying the patient's Medication Administration Record (MAR). Nurse DF witnessed Respondent draw the

morphine into a syringe, then walk into an adjacent department and disappear. Nurse DF waited for Respondent to return to the patient's room with the morphine, but she never came back. In the meantime, the alarm on the patient's peripheral intravenous line (I.V.) was beeping "occlusion." There was blood visible in the tubing and dried blood around the dressing. Nurse DF found Respondent in the nurse's station sitting at a computer charting and questioned her about administering morphine to a patient with an occluded I.V. Respondent stood up, stumbled towards the hall, turned and walked towards Nurse DF, and then tripped into the medication cart and wall. Another nurse witnessed Respondent's inability to walk. Respondent stumbled towards the medication room. She was observed holding onto the doorway for support and had difficulty entering the code to unlock the door. When she got the door opened, Respondent was observed nearly falling into the room; her speech was slurred and almost intelligible. Nurse DF spoke to the patient in Room 125-A; the patient was in no pain, did not ask for pain medication, and stated that no one gave him anything in his I.V.

19. Suspicious about Respondent's condition, Nurse DF went to the adjacent medical/surgery unit to see if the nurse for the patient in Room 108-A had asked Respondent to pull morphine. No one in medical/surgery knew anything about it. Nurse DF then went to the nurse for the patient in Room 130-A to see if she knew anything about the Dilaudid that had been pulled by Respondent. Nurse JF stated that her patient was quiet and sleeping and did not need any medication. Nurse DF re-checked the Pyxis.waste report – there was another dose of Dilaudid signed out for the patient in 130-A witnessed by another staff member.

20. At approximately 6:00 a.m., Respondent attempted to get Nurse DF to witness wastage for a new admission. Nurse DF declined to witness and so did the charge nurse.

21. On March 5, 2008, at approximately 6:30 a.m., Nurse DF reported the incidents to the unit manager, who started an investigation. Patients were interviewed, Pyxis reports were obtained from the pharmacy, MARs were reviewed, and statements were obtained from staff members. The results of the investigation are as follows:

a. Respondent twice medicated Nurse JF's patient in Room 130-A with Dilaudid without informing Nurse JF. Nurse JF stated she had been monitoring her

patient's pain level and she did not appear to have any pain. A pharmacy report indicated that Respondent pulled Dilaudid for the patient five minutes after her shift started and before report was given by the off-going staff. This was not documented in the nurse's notes or the patient's MAR. The Pyxis indicated that Respondent pulled narcotic medication for the patient at 1:58 a.m. Wastage was not completed until 3:35 a.m.

b. The Pyxis indicated that Respondent pulled Dilaudid on a patient in the medical/surgical unit (Room 108-A). The patient, who was not assigned to Respondent, had no documentation of pain in the chart. Respondent did not chart in the patient's MAR that the medication had been administered. Further, Pyxis indicated that Nurse EP witnessed the Dilaudid wastage, however, Nurse EP stated he did not witness the wastage.

22. As a result of her initial investigation, the unit manager told Respondent, who had already departed at the end of her shift, that she needed to return to the hospital to answer questions about the incidents. In an interview, Respondent stated that she is used to answering patients' call lights and that she medicated the unknown patient in Room 130-A because the patient was asking for something for pain. Respondent stated that she medicated another nurse's patient because the assigned nurse was on a break. Respondent stated that she gave morphine to Nurse DF's patient in Room 125-A because he asked for pain medication.

23. Shortly thereafter, Respondent was terminated from her employment for cause.

24. On or about March 14, 2008, the Board received a complaint from Linda Ruggio, the Chief Nursing Officer of Montclair Hospital Medical Center. The complaint alleged that on March 3 and March 4, 2008, while working her third training shift as a new employee, it was alleged that Respondent diverted controlled substances from patients for her personal use.

25. As a result of the hospital's complaint, the Board of Registered Nursing referred Respondent to the Maximus Diversion Program. During Respondent's March 19, 2008 intake interview, she admitted that she had been diverting and using Dilaudid on a regular basis for the past year, using it intravenously twice a shift, three times a week. Respondent admitted that she only used it at work and that as long as she did not work in a hospital, she would not use

it. Respondent admitted occasionally diverting Valium from her sister to deal with stress. Respondent also stated that she had used morphine at work, but it did nothing for her. Respondent reported that she had bouts and binges with methamphetamine and cocaine, but claimed not to have used either in eight years. Respondent stated several times during the intake interview that she had a weakness for Dilaudid.

26. On or about April 1, 2008, Respondent signed the Diversion Program Preliminary Agreement. The agreement required Respondent to participate in scheduled assessments, abstain from drugs and alcohol, submit progress and compliance reports, attend and document 12-Step meetings, attend a weekly Nurse Support Group, complete chemical dependency CEU's, submit to random body fluid samples, and enter an outpatient chemical dependency treatment program, along with additional terms and conditions. Respondent was suspended from working as a registered nurse until cleared by Maximus to return to work.

27. Respondent tested positive for benzodiazepines on April 9, 2008 and April 15, 2008. Respondent admitted she had used Valium (diazepam). After Respondent tested positive for ethyl glucuronide ("ETG"), a biomarker for alcohol, on May 16, 2008, Respondent was mandated to enter a residential drug treatment facility for a minimum of 30 days.

28. Respondent missed a random body fluid test with Compass Vision on June 28, 2008 and July 9, 2008. On July 7, 2008, Respondent tested positive for amphetamine and methamphetamine. Maximus determined Respondent had relapsed and directed Respondent on July 15, 2008 to return to an inpatient program for a minimum of 60-90 days.

29. From August 8, 2008 to September 2, 2008, Respondent entered and left two drug treatment programs. Respondent failed to submit 12-step cards and monthly self reports.

30. At a Disciplinary Review Committee meeting on September 25, 2008, Respondent was mandated to attend an inpatient drug treatment program. Respondent was instructed to call her case manager within 24 hours of the meeting with a verbal agreement that she would follow the program guidelines or she would be terminated from diversion and her case closed as a public safety risk. Respondent failed to contact her case manager.

31. Respondent was terminated from diversion on September 30, 2008. In a letter to Respondent dated October 1, 2008, she was informed by the Diversion Project Manager that she had been terminated from the diversion program as a public risk.

FIRST CAUSE FOR DISCIPLINE

(Incompetence - Failure to Chart Administration of Controlled Substances)

32. Respondent is subject to disciplinary action under section 2671, subdivisions (a)(1) and (d) of the Code in that on and between March 3, 2008 and March 4, 2008, Respondent failed to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse when she claimed to have administered narcotic pain medication (to wit, Dilaudid) to two unassigned patients without the knowledge or permission of the assigned nurses, and failed to chart the medication in the patient's Medication Administration Record, as described in paragraph 22, above.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

33. Respondent is subject to disciplinary action under section 2671, subdivision (a)(1) and (d) of the Code in that on and between March 3, 2008 and March 4, 2008, Respondent made an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse in that she charted that she administered a controlled substance, to wit, morphine, into a patient's I.V. line when in fact, the patient's I.V. line was occluded with blood, as described in paragraph 19, above. Further, Respondent claimed to have administered narcotic pain medication (to wit, Dilaudid) to two unassigned patients without the knowledge or permission of the nurses, and failed to chart the medication in the patient's Medication Administration Record, which could have led to over medication of the patient. The failure to provide care or to exercise ordinary precaution when Respondent knew, or should have known, could have jeopardized the client's health or life constitutes gross negligence.

///

///

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Falsification of Hospital Records)

34. Respondent is subject to disciplinary action under section 2762, subdivision (e) of the Code in that on or between March 3, 2008 and March 4, 2008, Respondent falsified entries in the hospital's Pyxis MedStation to access controlled substances and falsely report wastage that was not properly witnessed. Further, on March 4, 2008, Respondent falsified a patient's medical record when she charted that she administered morphine to a patient's I.V. and did not note that the patient's I.V. was completed occluded with blood, as detailed in paragraph 19, above.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Use of Controlled Substances)

35. Respondent is subject to disciplinary action under section 2762, subdivision (b), in that while on formal diversion with the Maximus Diversion Program, Respondent tested positive for controlled substances as described in paragraphs 27 and 28, above. On April 9, 2008 and April 15, 2008, Respondent tested positive for benzodiazepines. Respondent admitted she had used Valium (diazepam). On July 7, 2008, Respondent tested positive for amphetamine and methamphetamine.

FIFTH CAUSE FOR DISCIPLINE

(Termination From Diversion)

36. Respondent is subject to disciplinary action under section 2770.11 of the Code in that on or about September 30, 2008, Respondent was terminated from the Maximus Diversion Program as a public risk, as described in paragraphs 26-31, above.

///

///

///

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 692725, issued to Mona Lee Williams;

2. Ordering Mona Lee Williams to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 11/12/09

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SD2008802914

80319863.wpd